

<b>CUPS Assessment for Pediatric Shock</b>				
<b>Assessment</b>	<b>Critical</b> (Late shock)	<b>Unstable</b> (Early shock)	<b>Potentially unstable</b> (Mechanism for shock)	<b>Stable</b>
Pulse rate	Very fast or slow	Fast	Normal	Normal
Pulse strength	Weak central pulse, absent peripheral pulse	Normal central pulse, weak peripheral pulse	Normal	Normal
Capill refill	More than 5 seconds	3–5 seconds	2–3 seconds	2–3 seconds
BP	Low	Normal	Normal	Normal
Skin	Very pale, mottled, or blue; cool	Normal, pale, or mottled; cool	Normal	Normal
<b>Actions</b>	Immediately open airway, suction, give high-concentration oxygen, assist ventilation as needed; control bleeding, place in shock position, keep warm, and transport	Move quickly; give high-concentration oxygen, reassess frequently; control bleeding, place in shock position, keep warm, and prepare for transport	If significant mechanism for shock is found (such as a fall from a 5th-floor window) give high-concentration oxygen, control bleeding, immobilize, and transport; begin focused history and detailed exam during transport	Move on to focused history and detailed physical exam; if no mechanism for shock, prepare for routine transport

*Based on CUPS Assessment Table © 1997 N. D. Sanddal, et al. Critical Trauma Care by the Basic EMT, 4th ed.*

Assessment Findings for Pediatric Shock			
<i>NOTE: Children in early or late shock may present with some, but not all, of the assessment findings below. Children should be treated for shock if several of the listed assessment findings are present.</i>			
Assessment	Normal	Early	Late
Mental status	Alert, responsive	Anxious, agitated	Abnormal (V, P, U)
Muscle tone/ Body position	Normal, able to sit	Normal or somewhat limp	Limp
Airway	Open	Open or maintained with positioning	Requires positioning; may need adjunct
Breathing rate	Normal	Fast	Very fast or slow
Breathing effort	Normal	Slightly increased	Usually increased; sometimes decreased
Pulse rate	Normal	Fast	Very fast or slow
Central pulse	Normal	Normal	Weak
Periph pulse	Normal	Weak	Absent
Skin color (extremities)	Normal	Normal, pale, or mottled	Very pale, mottled, or blue
Skin temp	Normal	Cool	Cool
Capill refill	2–3 seconds	3–5 seconds	More than 5 seconds
BP*	Normal for age	Normal for age	Low for age
<b>Actions</b>	Work at moderate pace through focused history and detailed physical exam; be prepared to reassess condition	Move quickly; give high-concentration oxygen, control bleeding, place in shock position, and keep warm; reassess frequently and prepare for transport	Immediately open airway, suction, give high-concentration oxygen, assist ventilation as needed; control bleeding, place in shock position, keep warm, and transport

\*In children aged three years or younger, a strong central pulse is a good indication of adequate blood pressure.

Pediatric Pulse Rates		
Age	Low	High
Infant (birth–1 year)	100	160
Toddler (1–3 years)	90	150
Preschooler (3–6 years)	80	140
School-age (6–12 years)	70	120
Adolescent (12–18 years)	60	100

*Pulse rates for a child who is sleeping may be 10 percent lower than the low rate listed.*

Low-Normal Pediatric Systolic Blood Pressure	
Age*	Low Normal
<i>Infant (birth–1 year)</i>	<i>greater than 60*</i>
<i>Toddler (1–3 years)</i>	<i>greater than 70*</i>
Preschooler (3–6 years)	greater than 75
School-age (6–12 years)	greater than 80
Adolescent (12–18 years)	greater than 90

*\*Note: In infants and children aged three years or younger, the presence of a strong central pulse should be substituted for a blood pressure reading.*